BEYRER
DECLARATION

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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ALLIANCE FOR OPEN SOCIETY INTERNATIONAL, INC. and OPEN SOCIETY INSTITUTE,

Plaintiffs,

v.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT and ANDREW S. NATSIOS, in his official capacity as Administrator of the United States Agency for International Development,

Defendants.

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DECLARATION OF CHRIS BEYRER, MD, MPH

I, CHRIS BEYRER, declare, under penalty of perjury under the laws of the United States of America, that the following is true and correct:

1. My name is Chris Beyrer. I submit this declaration as an expert on the epidemiology of HIV/AIDS and HIV prevention methods in support of the Plaintiffs' motion for a preliminary injunction.

I. INTRODUCTION AND SUMMARY

2. HIV/AIDS continues to spread rapidly across the world. The number of persons who are infected continues to rise, particularly in most parts of Africa and Asia. In many regions, when the HIV/AIDS epidemic begins it is concentrated in small populations of high-risk groups, such as sex workers, drug users, and others. Staunching the spread of the epidemic among those populations is critical to slowing the epidemic's spread to the rest of the population. Public health literature has shown that effective HIV prevention efforts among sex

workers and other high-risk groups depend on establishing a relationship of trust with them, particularly because these groups are often highly stigmatized and marginalized. Establishing trust requires approaching sex workers and others in a non-judgmental fashion. In some regions, it is necessary to advocate for a change in the way sex workers are treated by law enforcement officials because when sex work is treated punitively sex workers go underground, avoiding doctors, outreach workers, and others who want to provide them HIV prevention, education, and condoms.

3. In 2003, Congress passed the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (the "Global AIDS Act"); it implements the President's Emergency Plan for AIDS Relief, which is a five-year global strategy for fighting HIV/AIDS by focusing on education, research, prevention, treatment, and care of persons living with HIV/AIDS. Among the provisions of the Global AIDS Act is a requirement that "no funds made available to carry out this Act . . . may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking" ("the pledge requirement"). I understand that the United States Agency for International Development ("USAID") has recently begun enforcing this provision against U.S.-based organizations after refraining from doing so for a year and a half. Acquisition and Assistance Policy Directive 05-04 ("AAPD 05-04"), the directive by which USAID enforces the provision, does not define "opposing prostitution." From counsel for the Plaintiffs, I understand that AAPD 05-04 may bar some or all of the following activities: (i) advocacy for legalization of or reduced penalties for sex work; (ii) organizing sex workers; (iii) working with sex worker unions or other sex worker collectives; and (iv) engaging in non-judgmental outreach to sex workers, including through peer outreach.

4. In preparation for providing this declaration, I reviewed various materials, including information provided to me by the Plaintiffs' counsel regarding the Global AIDS Act and its implementation, and the activities of the Plaintiffs Alliance for Open Society International, Inc. ("AOSI") and Open Society Institute ("OSI"). In addition, I reviewed literature in the field of public health regarding HIV/AIDS prevention work. The list of references that I consulted is attached to this declaration as Exhibit A.

II. PROFESSIONAL BACKGROUND

5. I received a Bachelor of Arts degree *cum laude* in History from Hobart and William Smith Colleges in 1981, and I completed my M.D. *cum laude* from the State University of New York Health Sciences Center in 1988. After completing my medical degree, I undertook a one-year internship (1988-1989) in Family Medicine at the University of Wisconsin. I then moved to Johns Hopkins University, where I did my residency in General Preventative Medicine while I was also a Fellow at the Division of Infectious Diseases in the Department of Medicine. While doing my residency I also completed a Masters Degree in Public Health ("MPH") with a focus on International Health at Johns Hopkins University School of Hygiene and Public Health. I was Board Certified in Preventative Medicine and Public Health in 1995. A copy of my curriculum vitae is attached to this declaration as Exhibit B.

6. I am currently an Associate Professor in the Departments of Epidemiology and International Health at Johns Hopkins Bloomberg School of Hygiene and Public Health. I also serve as the Director of the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Hygiene and Public Health, which I founded in 2004 to conduct research, education, and advocacy on the impact of human rights violations on the general health of populations.

7. For approximately thirteen years, I have researched, conducted fieldwork, and written about populations at high risk for being infected with Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS). The focus of my research and fieldwork is on the epidemiology and prevention of HIV/AIDS, and HIV vaccine research and development. While I have participated in HIV projects in countries throughout the world, I have spent substantial time in Southeast Asia, and to my knowledge, I am one of a handful of U.S. public health specialists to have conducted significant research on the spread of HIV in Tajikistan.

8. I began working with populations at high risk for contracting HIV/AIDS as a study physician in 1990 while working for the "ALIVE Clinic" and for the "SHARE Study" in Baltimore, Maryland, where I conducted clinical evaluations of subjects involved in HIV cohort studies of intravenous drug users and gay men.

9. In 1992, I began my international work with populations at high risk for contracting HIV/AIDS when I served as Field Director for the Preparation for AIDS Vaccine Evaluations ("PAVE") and HIV NETWORK ("HIVNET") Projects in Northern Thailand. These were a series of joint projects between Johns Hopkins, the United States National Institutes of Health, Chiang Mai University, the Royal Thai Army, and the Ministry of Public Health in Thailand. In my role as Field Director, I was responsible for the enrollment and maintenance of a series of epidemiologic studies of high-risk, HIV-negative individuals in Northern Thailand.

10. While working on the PAVE and HIVNET Projects in Thailand, I had a three-year public health policy consultancy with the Southeast Asian Information Network. In that capacity, I created HIV prevention programs for Radio Free Burma, BBC Burmese Language Service, and Voice of America.

11. Since 1997, I have been the Director of the Johns Hopkins University Fogarty AIDS International Training and Research Program. In my role as Director, I serve as the Principal Investigator for the program, which aims to increase capability of developing country scientists to conduct advanced research in HIV/AIDS-related health issues. During this time I also created and directed a new core program at the Johns Hopkins Center for AIDS Research ("CFAR") focused on international HIV/AIDS prevention treatment and research.

12. While working as the director of various programs and research initiatives at Johns Hopkins and elsewhere, I have continued to conduct field research as a Principal Investigator in Thailand, and throughout Asia and Eastern Europe, on populations at high risk for contracting HIV/AIDS, including sex workers and intravenous drug workers. One of my projects is a cross-sectional study of 500 drug users in Dushanbe, Tajikistan. We are measuring risk behaviors and disease burden, including HIV and Hepatitis C Virus infection, with the help of trained outreach workers.

13. I am a member of numerous domestic and international professional advisory boards and steering committees in both the government and non-government organization ("NGO") context that address HIV and AIDS related issues. I have had and continue to have various consultancy positions, many of which are affiliated with the World Bank's international HIV/AIDS programs, including, for example, the World Bank Institute's HIV/AIDS Treatment Options for Developing Countries.[1]

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[1] As indicated on my attached curriculum vitae, I received a one-time grant in the amount of $82,000 from OSI's Development Fund, which at the time constituted a small percentage of my total funding for research and training. The grant period ended July 1, 2005.

14. I have published over eighty scholarly articles in various medical and public health journals. Several of these articles focus on the commercial sex industry in Thailand. A list of my publications is included in my attached curriculum vitae.

III. THE HIV/AIDS PANDEMIC

15. Twenty million people have died from AIDS, 37.8 million are living with HIV, and the relentlessly expanding epidemic continues to destroy lives (UNAIDS, 2004).[2]

16. A combination of structural and behavioral factors plays a central role in making individuals and groups vulnerable to HIV infection. Adverse conditions such as poverty, social stigma, and gender-based and other forms of discrimination exacerbate the risk of becoming infected with HIV.

17. In many regions, when the HIV/AIDS epidemic begins, it is concentrated among high-risk groups such as sex workers. In various communities/societies around the world, sex workers are the conduits through whom HIV/AIDS spreads into the general population (World Bank, 1997; Rao, 2000; USAID, 2001). For instance, men who have sex with sex workers often spread HIV/AIDS to their wives and other women. We also know that sex workers are parts of much larger and broader networks of heterosexual transmission of HIV, and are connected to injection drug related epidemics (UNAIDS, 2003). By intervening effectively with sex workers and other high-risk groups, the spread of the epidemic to the general population can be slowed (Latkin, 2005; World Bank, 1997).

18. An important way to combat the spread of HIV is to keep the rates of HIV infection low among sex workers, and to encourage the use of safe sex methods between sex workers and their clients (Kerrigan, 2004; Rao, 2000; UNAIDS, 1999; WHO, 2002). Providing

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[2] Citations are to authorities set forth in the table of authorities attached to this declaration as Exhibit A.

sex workers with access to education, condoms, and other prevention tools is very effective in curbing the spread of the disease within this community and the general population (UNAIDS, 2001, 2004). It is essential to involve members of the target high-risk community, such as sex workers, in delivering the message of HIV/AIDS prevention (USAID, 2001).

19. Unfortunately, intervention programs worldwide have encountered significant barriers to effectively reducing rates of transmission; key among these have been stigma and discrimination (Cameron, 2000; Castro, 2005; Mann, 1997; Mann, 1999; Nyblad et al., 2003; Rankin, 2005). As USAID has long recognized, "[s]tigma and discrimination push people in high-risk groups (e.g., sex workers, injecting drug users) underground, making them difficult to reach through prevention programs and thus creating more opportunities for HIV/AIDS to spread to the general population" (USAID, 2001).

20. Sex workers are especially vulnerable to the circumstances and social patterns that are conducive to the spread of HIV. Sex work is an illegal activity in many places, and many legal frameworks are oriented towards penalizing sex workers. In countries with limited civil rights protections, police harassment and abuse of sex workers is common, and police and security involvement in the sex industry is the rule rather than the exception (Zimmerman et al., 2003). In these settings, fear of incarceration makes sex workers less likely to seek health or social services and more likely to continue their high-risk behaviors underground (Wolffers, 2003; UNAIDS 2002; World Bank, 1997). Approaches that penalize sex work can exacerbate, not improve, rights violations and security for these vulnerable women (Zimmerman et al., 2003), and in turn can hinder efforts to prevent the spread of HIV/AIDS within this group by making access to women more difficult and dangerous for outreach workers, public health staff and peer educators. In contrast, in Brazil and Senegal, where sex

work is decriminalized, outreach programs for sex workers to encourage the use of preventive measures have been quite successful in keeping rates of HIV low (Ahmad, 2001; Homaifar, 2005).

IV. APPROACHES TO HIV/AIDS PREVENTION PROGRAMS – BEST PRACTICES

21. Public health professionals rely heavily on published "best practices" reports from global health organizations such as the World Health Organization ("WHO") and the United Nations Program on HIV/AIDS ("UNAIDS") for the programmatic design of HIV interventions. USAID, through its Horizons project, also works with various organizations to identify successful HIV/AIDS prevention efforts and to understand why they work (USAID, 2002).

22. Best practices can range from specific training techniques to entire programs. Some best practices are backed by the strongest evidence in the form of results of systematic reviews of randomized controlled trials. It is accepted within the public health field that some best practices are based on evidence-based studies that are less rigorous but which may be the only measures available to evaluate the effectiveness of certain practices.

23. Best practices in HIV prevention recognize that while sex work may be illegal, and may be exploitative or morally wrong, the sex workers themselves need services, protection, peer outreach, and help and support from public health professionals to reduce their risks for HIV infection. Moreover, most public health professionals see a clear distinction between trafficked and involuntary sex work, including debt-bonded labor in this industry and sexual servitude, and more voluntary forms of sex work. There is almost no debate either in political or public health worlds that sex trafficking is a crime and that those working in involuntary servitude in sex work (or any other form of forced labor) should be freed.

24. The most effective HIV prevention programs have shared a non-judgmental and engaged approach of working closely with sex workers and their organizations and advocates. In order to get sex workers to accept and utilize the tools they need to stay alive, it is generally necessary to first build a relationship of trust with them. Best practices in HIV prevention also have utilized peer education approaches, in which sex workers themselves are active partners in the prevention and support effort. Engagement with sex worker organizations has also been essential to the best practices examples detailed below.

25. In conducting outreach to sex workers, public health professionals often struggle to make sure that law enforcement efforts do not work at cross purposes with HIV prevention work. Some best practices have involved advocating for the reduction or removal of penalties applied to sex workers so that such penalties do not interfere with outreach efforts. ((UNAIDS, Jan. 1999, 2003; WHO, 1999; Wolffers, 2003). For instance, some HIV prevention programs have had to advocate with local police and government officials to discourage them from engaging in crackdowns and arrests of sex workers that thwart HIV prevention efforts. One example of such efforts is a project in Bangladesh called "Shakti," a project implemented by CARE Bangladesh that conducts outreach with brothel-based workers; Shakti employed strategies such as high quality repetitive contact with sex workers, peer education, and provision of the means for and facilitation of behavior change at the community level. When sex workers organized for their safety and basic human rights after the brutal murder of a young sex worker, CARE took the simple stance of supporting the sex workers in their campaign for basic human rights, including the right to work; after the High Court of Bangladesh declared that sex work is not illegal, CARE found that it strengthened options for HIV prevention work (UNAIDS, 2000).] Another example is from the well-known Thai 100% Condom Campaign. One of the most

effective strategies was working with police forces to halt sex venue raids as long as management of these venues complied with condom promotion and with not having under age sex workers (Ainsworth, 2003).

26. In the past, USAID has recognized the importance of working with sex workers, such as the success of Philippines of working with registered sex workers to increase their regular condom use and Senegal's system of registration of commercial sex workers that allows a framework for reaching this group with educational and health campaigns (USAID, 2001).

27. Similarly, Edward Green, who serves on the Presidential Advisory Council for HIV/AIDS, recognized the importance of outreach to sex workers in his recent book Rethinking AIDS Prevention: Learning From Successes in Developing Countries (2003). In a chapter on effective approaches to HIV prevention in Africa, Green upheld Senegal for its success in combating the AIDS epidemic, particularly with respect to high-risk populations like commercial sex workers. According to Green, Senegal has a "health-enlightened program" for sex workers that are registered with the government. By decriminalizing and destigmatizing sex work, the government of Senegal has been able to provide effective health outreach in the form of free physician health care and AIDS and STD education for sex workers and their families. These efforts, combined with a high prevalence of condom use among sex workers, are cited as factors likely to have kept HIV rates in Senegal from climbing to the rates found among sex workers in other countries. In addition to Senegal, Green cited the Philippines, Indonesia, the Dominican Republic, and Thailand as countries that have stabilized or decreased the prevalence of HIV, due in part to their outreach to sex workers with peer education and condom distribution (Green, 2003).

28. In the public health field, it is customary to use the terms "sex work" and "sex workers" in place of "prostitutes" and "prostitution." This is an essential aspect of the non-judgmental approach to working with this high-risk group, which already suffers from great stigmatization. International organizations such as the WHO, UNAIDS and the World Bank recognize the importance of using non-stigmatizing terms "sex work" and "sex workers" (UNAIDS, 2002; WHO, 1999). The use of stigmatizing terms such as "prostitutes" hinders efforts to reach out to this community, and in turn hinders efforts at HIV/AIDS prevention (UNAIDS, 2002). As USAID once noted in its June 2002 report to Congress:

> HIV/AIDS prevention and care programs do not operate in a vacuum. To be effective, the larger context in which they operate must be supportive. For this reason, USAID addresses a number of issues that increase communities' vulnerability to HIV/AIDS, including *stigma and discrimination*, gender inequality, food insecurity, lack of infrastructure, and capacity within the country for political and legislative advocacy.

(USAID, 2002) (*emphasis added*).

V. EXAMPLES OF HIV PREVENTION BEST PRACTICES

A. World Health Organization

29. The WHO produced a *Summary Booklet of Best Practices in the Field of HIV* in 1999 and more recently created a *Toolkit for targeted HIV/AIDS prevention and care in sex work settings* in 2005. The Summary Booklet describes how initial HIV prevention programs primarily promoted and distributed condoms to sex workers and distributed information about the virus. They focused on the sex worker, but not their clients or other participants in the industry. Because the initial programs failed to address the primary needs of sex workers, they had only limited success (Kerrigan, 2004; Mgone, 2002).

30. According to the WHO, the most effective programs use outreach and peer networks to reach sex worker communities. Peer education is commonly utilized in public

health interventions to effect changes in knowledge, attitudes, beliefs, and behaviors at an individual level. At the societal level, it can modify norms and stimulate collective action among members of the same group (Population Council, 2000). Peer workers are oftentimes former or current sex workers—knowledgeable "insiders" in the industry who are more successful at communicating and building trust with the target population. They embody the core of an HIV intervention. However, the most effective programs also involve people who influence commercial sex activity. This includes owners and managers of bars, hotels, and brothels; clients of sex workers; social workers; government officials; and police.

31. With peer workers in place, the WHO recommends focusing initially on the following three outcomes: (i) safer sex and increased condom use; (ii) increased sex worker involvement and control over working and social conditions; and (iii) reduced incidence of sexually transmitted diseases (STDs). Deliverable commodities, services, and actions are of paramount importance to effective communication efforts. These include the provision of adequate male latex condoms of high quality, drugs to treat STDs, and clean needles where sex work is linked to injection drug use. It is important to offer STD management or HIV support services and create an environment conducive to behavior change. This might mean persuading brothel owners to insist on condom use or reducing police violence against sex workers. Successful programs that have addressed these environmental-structural factors have been implemented at local, regional, and national levels including those in Australia, the Philippines, Dominican Republic, Thailand, and Cambodia (Kerrigan, 2005; Rojanapithayakorn, 1996; WHO, 2005). Other apparent health and social needs require attention as the intervention develops. Through interviews, focus groups, or informal meetings the sex workers themselves should prioritize these needs. The sex workers' needs can include organizing them to help

reduce police harassment or repressive laws, policies and practices (UNAIDS, 2002; WHO, 2002).

32. Under the Global AIDS Act, recipient organizations that follow the WHO best practices might be found to violate the requirements of the statute. As described above, the WHO best practices focus on outreach and peer networks to reach sex workers. In addition, WHO best practices recognize the importance of reducing police harassment of sex workers and changing laws and policies (UNAIDS, 2002; WHO, 2002). WHO emphasizes the need for policies that provide places where sex workers can access health and counseling services as well as condoms and lubricant without facing arrests. If the pledge requirement is found to disallow such efforts, it would undercut the foundation of the WHO best practices for organizations that receive money under the Global AIDS Act.

B. UNAIDS Best Practices

33. The UNAIDS recommendations for reaching vulnerable populations closely resemble those published by the WHO. In its best practices collection titled *Sex work and HIV/AIDS* (2002), UNAIDS details the need for a multi-faceted approach when addressing the HIV/AIDS epidemic among sex workers. The process begins by understanding the forces that drive people from a particular community into sex work.

34. There are countless studies that document the socio-economic factors that compel persons into an extremely widespread industry of the exchange of money, goods or services for sex. In a society with visible socio-economic disparities, sex work is affordable for the client and an economic opportunity for the worker. Unfortunately, a difference in personal power exists. For women, this results in the inability to insist on sexual fidelity and to negotiate safe sex (World Bank, 1997). One of the most common factors for entering sex work,

particularly for women and children, is poverty and limited economic opportunities. One-half of sex workers in Calcutta reported extreme poverty as the number one reason for entering this industry, while another 22 percent cited "family disturbances," indicating a breakdown in familial social support (Chakraborty et al., 1994). The majority of persons who turn to sex work have few other options. With limited skills and little or no education, they enter into, either willingly or through coercion, sex work to support themselves and their families.

35. According to UNAIDS, key effective strategies include: (i) providing condoms and education regarding their correct use, teaching negotiation skills, and advocating supportive policies to promote safer sexual behavior among sex workers, clients and institutions or groups associated with sex workers, such as police and sex workers' partners; (ii) promotion and availability of STD prevention and care services; (iii) outreach work that includes health, social and legal services, such as protection from abusive partners, child protection services for children of sex workers, and consultation on how to get free of debt; (iv) peer education among sex workers, clients and associated groups; (v) care of people living with HIV/AIDS; and (vi) advocacy for policy and law reform at national and local levels, including respect of human rights. UNAIDS points out the importance of addressing the environmental-structural factors when designing an intervention. Education and behavior change theories focused on the individual, although needed, are not sufficient when used alone. Interventions must focus on the elements that extend beyond the control of the individual, such as social norms, material and human resources, and policies and legislation that facilitate or constrain personal behavior. Supportive policies, for example, can ensure that sex workers attending health clinics will not be targeted for arrest by police, and that other venues used by sex workers will be "safe places."

Legal and policy reform can provide these populations freedom from arbitrary arrest and detention and protection for the victim in cases of rape.

36. UNAIDS recognizes the need to improve the environment and conditions for sex workers as part of an effective HIV/AIDS prevention program:

> Where sex work is a recognized occupation, even if illegal, priority should be given to improving working conditions . . . . For example, courts, government administration and police can all improve their responses to violence against sex workers. They can also refrain from impeding sex workers' access to suitable premises and/or discouraging possession of condoms, and instead encourage adherence to protective practices.

(UNAIDS, 2002). UNAIDS also stresses that human rights violations against sex workers seriously impede HIV/AIDS prevention efforts. Its recommended strategies to address these problems include "education and awareness training for police officers, protective regulations, and enforcement of existing laws and workplace sanctions that prohibit discrimination and punish violence" (UNAIDS, 2004).

37. It is my understanding that, if organizations receiving funding from the US government follow some of these strategies, they could be viewed as violating the requirements of AAPD 05-04.

C. World Bank Best Practices

38. The World Bank has been a major funder of developing country HIV/AIDS programs. It promotes interventions that reduce or eliminate the risk of HIV transmission among people who engage in behaviors that put them at higher risk. The recommended interventions include voluntary counseling and testing, needle exchange, and drug dependency treatment. The World Bank also supports interventions focused on commercial sex

workers that have proven to be effective: peer education, diagnosis and treatment of STDs, and the promotion of consistent condom use (World Bank, 2003).

39. The World Bank identifies the Sonagachi Project in Calcutta, India, as an example of an intervention that used the available research strategies to create a successful and replicable way to reduce rates and prevent new cases of HIV (Jana, 2004). As a result of this project's efforts, Calcutta has seen remarkably low rates of HIV infection among sex workers (11%) as well as high rates of condom use (from 3% in 1992 to 90% in 1999), while other Indian cities have experienced quite a different response to the HIV epidemic (NACO, 1999, 2001). In areas such as Bombay, Delhi, and Chennai, as many as 50 to 90 percent of sex workers have tested positive for HIV (Gangakhedkar et al., 1997; UNAIDS, 2002).

40. The Project achieved this success by reframing the focus of the intervention, from an issue of individual motivation and behavior change to a problem of community disenfranchisement, which would engage the women in roles of power and decision-making within a program. This included a shift in language, from "prostitution" to "sex work"—to depict an industry generating commerce rather than a crime depicting immorality (Newman, 1998). As time progressed, positive experiences were felt in the community, and the problem of HIV was redefined. It became a communal issue, rather than one of the individual.

41. Peer outreach workers initiated the program by handing out free medication for STD treatment, other antibiotics, and condoms to sex workers in several communities. After they gained the sex workers' respect and trust, they eventually made home visits and accompanied the women to clinics for testing. Informal daily meetings in the "red light" areas as well as occasional group trainings and educational events allowed the sex workers and the outreach workers to provide feedback on the strengths and weaknesses of the program.

42. Over the long term, the group began to mobilize collective power. They challenged environmental barriers such as literacy and limited economic resources. Education programs for sex workers and their children were established. Loan programs were piloted in collaboration with local credit unions to address the need for immediate cash assistance in emergencies. In the past, sex workers were often tempted to forego condom use with clients for additional pay. Dedicated professional advocates who initially gave them a political voice transferred leadership roles to the peer outreach and sex worker community, thus giving them their own voice. Through all of this, the sex workers internalized messages of self-confidence, self-reliance, and a future for themselves and their children, including the right of public education and immunizations for their children and adult literacy programs. The Sonagachi project saw a decrease in sex work as women began leaving the industry following the successful outreach program (Jana, 2004).

43. It is important to highlight from this case study that the intention of the researchers was to implement an effective HIV prevention program by providing a means to access care and to promote healthy behaviors among sex workers. Although they witnessed increased literacy and newly acquired skills, both promoting economic stability, this was not their initial goal. Instead, they began with realistic goals: create health clinics for sex workers, have them use the clinics, and reduce rates of STDs and HIV. If the latter came first, the project would have failed. The sex workers' own priorities and concerns within a larger context of care and protection would have been ignored, giving this exploited population a reason not to trust the Sonagachi project staff.

44. In a July 15, 2005 letter to USAID Administrator Andrew Natsios, Representative Mark Souder and twenty-seven other members of Congress identified the

Sonagachi project, which as explained above has been extremely effective in curtailing the spread of HIV/AIDS in its target community, as "pro-prostitution." I do not know whether USAID will agree with this characterization, and whether USAID will determine that projects like the Sonagachi project to be in violation of the pledge requirement. I do know, however, that the public health community agrees that this has been one of the most successful efforts to reduce HIV rates in a particular community.

D. Brazil's Successful HIV Prevention Program

45. Brazil's program is a key example of approaches that have met the dual goals of (i) reducing stigma and rights violations against sex workers and (ii) controlling the spread of HIV. In Brazil, the evidence suggests that an early and effective response to the HIV spread among sex workers and clients can limit the spread of the virus (Ainsworth et al., 2002). However, it requires leadership, innovative programs, and political will.

46. An important component of the success of Brazil's program was the close and sustained engagement of government and non-governmental groups, including sex worker support and advocacy groups (Ainsworth et al., 2002). At the request of grassroots organizations and NGOs organized by sex workers themselves, Brazil's program adopted the term "sex professionals" for sex workers (Gauri et al., 2005).

47. The engagement of NGOs and civil society in the organization and delivery of targeted interventions strengthened the position of these often marginalized stakeholders, helping to sustain commitment for prevention among the populations most likely to contract HIV. Over the course of the 1990s, Brazil sharply increased the number of interventions targeted at men who have sex with men (MSM), sex workers, and intravenous drug user populations. During the period 1999–2003 the program implemented 547 projects which

covered an estimated 899,386 sex workers, 631 projects reaching some 145,807 intraveneous drug users (an estimated 18.2 percent of that population), and 486 projects covering some 3,074,980 men who have sex with men, reaching a reported coverage of 96 percent of that population.[3] These figures include both public sector and NGO-executed projects (Gauri, 2005).

48. Brazil's program—including its outreach to sex workers—has been a clear success compared to other efforts around the world, and is recognized as a preeminent model in the area of HIV/AIDS prevention (Berkman, 2005; Piot, 2001). For instance, in 1990, Brazil and South Africa had roughly the same rate of prevalence of HIV among adults, just over 1 percent. Now 20 percent of South African adults have HIV or AIDS, while Brazil's rate has dropped (Berkman, 2005; Walker, A.R., Walker, B., Wadee, A.A., 2005).

49. In response to the Global AIDS Act's requirements, Brazil has chosen to forego US funding in favor of maintaining its current program that has enjoyed such great success. Brazil has decided that complying with the requirements of the Global AIDS Act, including the anti-prostitution pledge, would be harmful to Brazil's HIV/AIDS prevention efforts (Basu, 2005). If an organization receiving funding under the Global AIDS Act seeks to follow the successful practices of Brazil's program, it would risk violating the Global AIDS Act's pledge requirement.

E. Thailand 's Successful HIV Prevention Program

50. Similarly, in Thailand, evidence also suggests that an early and effective response to the HIV spread among sex workers and clients can limit the spread of the virus (Ainsworth et al., 2002).

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[3] It should be noted that coverage rates are in need of further substantiation.

51. Thailand's well known "100% Condom Campaign" used a pragmatic and public health approach to prevention. It focused on getting public health staff to sex venues, bars and clubs; vigorously promoted condom use and medical treatment; and provided compassionate and targeted counseling (Hanenberg, Rojanapithayakorn, 1998). The Thai government used its own resources to provide up to 60 million free condoms a year through the 1990s for the program.

52. The scientific evidence for the Thai program's efficacy is overwhelming (Nelson et al., 1996). Rates of infection in northern Thai army conscripts peaked at over 12 percent of all 21-year old men in 1991, and were under 1 percent a decade later (Nelson et al., 2002). Throughout this time period, prostitution remained illegal, but the Thais focused their police efforts on just two key domains of prostitution: they vigorously enforced a policy that all sex workers had to be over age 18, and they closed down venues which refused to enforce 100 percent condom use for all clients.

53. One unforeseen effect of the 100% Condom Campaign was an overall decline in the number of women actively working in the Thai sex industry. In January 1989, there were 86,201 female sex workers. By January 1994, the number fell to 66,035. Interviews with former sex workers revealed that increased AIDS education and awareness among those engaged in the commercial sex industry including clients and brothel owners, as well as improvements in the economy, expanded job opportunities, and skills building programs offered by sex worker unions and organizations, influenced many women to find other work (Hanenberg, Rojanapithayakorn, 1998; Manopaiboon, 2003).

54. An important component of the success of the Thai program, as in Brazil's program, was the close and sustained engagement of government and non-governmental groups,

including sex worker support and advocacy groups (Ainsworth et al., 2002). In Thailand, groups organized by and for sex workers requested the government to change their terms of referral from prostitution and commercial sex worker, to sex worker, which they argued was less stigmatizing.

VI. HIV/AIDS IN CENTRAL ASIA

55. The Central Asia region, which includes Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, is experiencing one of the world's fastest growing rates of HIV. Reported cases jumped from about 500 in the year 2000 to over 8,000 in 2004. These figures represent only cases reported by the health services and police. The actual rate of HIV is likely much higher, since systematic surveillance is limited by poor financial resources and infrastructure (World Bank, 2005; Aceijas et al., 2004; UNAIDS, 2004).

56. In Uzbekistan, Kazakhstan, and Tajikistan, the epidemic is concentrated among young people who inject drugs and/or engage in commercial sex (UNAIDS, 2004). The region is situated at the crossroads of the main drug-trafficking routes. Heroin in most places is cheaper than alcohol, making its sale and use highly prevalent (Stachowiak, 2005).

57. As explained previously, understanding the social factors that influence the spread of HIV within a society is fundamental to developing an effective response. According to a 2003 report on Tajikistan, Kazakhstan, and Uzbekistan by the U.S. Bureau of Democracy, Human Rights, and Labor, the political climate in these three countries is dominated by authoritarian regimes with limited civil rights and numerous human rights abuses (U.S. Department of State, 2003).[4] The list of abuses against women in the region is long. Women

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[4] The report details numerous human rights abuses by members of the government security forces, harsh and life threatening prison conditions, arbitrary arrest and detention, extreme restriction of freedom of press and speech, and a clear disparity of income between a small number of former pro-government officials

face diminishing educational opportunities and increased poverty; cultural norms discourage women and their families from speaking openly about gender-based crimes. For instance, the law in Uzbekistan and Tajikistan prohibits rape, yet there are no extant reports on the number of rapists prosecuted, convicted, or punished. There are a number of domestic and international NGOs that address violence against women, but receive extremely limited funding from the governments. In this part of the world, the official approaches to HIV prevention among sex workers has either been negligent or repressive (USAID, 2001).

58. Many observers, including local NGOs, believe that the deteriorating economy has increased the number of women, especially ethnic minorities, engaged in this work. It was recorded that Tajik police officers used the threat of prosecution to extort money from these women (Department of State, 2003).

VII. HIV/AIDS PREVENTION WORK OF AOSI AND OSI

59. Organizations working in the Central Asian countries to reduce the soaring AIDS epidemics there are challenged by highly discriminatory societies and oppressive governments. Based on information provided to me by lawyers for AOSI, it is clear that AOSI is among the organizations that fill a need that these governments cannot, or will not, by (i) providing knowledge and experience on how to contain the HIV epidemic, (ii) implementing best practices, and (iii) allocating money to run needed intervention programs. Organizations like AOSI are aiding local NGOs and other international NGOs in this region by building local capacity. This is accomplished by sharing educational resources, public health strategies and other information to move marginalized groups out of their disenfranchised status. If the work of OSI and AOSI in the Central Asia region were barred by USAID, it would have drastic

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benefiting from narcotics trafficking and the vast majority of the population.

consequences for efforts to prevent the spread of HIV/AIDS in the Central Asia region and elsewhere.

60. I understand from lawyers for AOSI and OSI that both organizations help publicize best practices regarding the fight against HIV/AIDS. For example, they have told me that OSI's Sexual Health and Rights Program has launched a listserv to provide a forum for interested stakeholders to share information, opinions, resources, and linkage opportunities related to service delivery, policy and advocacy issues that affect the health, safety and well-being of sex workers in Eastern Europe and the former Soviet Union. SHARP encourages participants to post content regarding best practices, service gaps, model legislation, advocacy strategies, and new initiatives.

61. Likewise, lawyers for AOSI and OSI have informed me that both organizations intend to sponsor a conference this fall to bring together members of different advocacy and service delivery communities – such as domestic and international groups, and groups working with sex workers and victims of trafficking – to discuss key policy issues.

62. If on the listserv or at the conference participants want to discuss best practices they may well need to discuss some or all of the following: 1) support or advocacy for the reduction or removal of penalties for sex work; 2) the organization of sex workers into unions or other groups; and/or 3) working with, or talking about, sex work in a non-judgmental fashion.

VIII. CONCLUSIONS

63. The United States has been by far the largest funder for the global response to HIV/AIDS. It has also been the largest funder of research in HIV, including prevention research, which has allowed for the evidence-based establishment of best practices in HIV prevention for those at risk, including sex workers.

64. The best practices show that we need to engage the high-risk community of sex workers through non-judgmental and comprehensive approaches that address their myriad needs, including policy and legal changes.

65. The demand that organizations adopt policies "opposing prostitution" in order to receive funds to do this work undermines the very goals of both organizations like OSI and the US government. All working on these difficult problems agree that sex workers themselves need our compassion, support, and engagement. But if organizations have to oppose prostitution on principle, they lose significant ability to work with sex workers who intend to continue working. Furthermore, for some sex worker groups, like Sonagachi in India and the sex worker organizations of Brazil, the demand to "oppose prostitution" would run counter to their core mission—empowerment of sex workers and reductions in police and security harassment.

66. In settings as challenging as Central Asia, where governments are weak and police corrupt, the limitations of this policy could be even more severe for already vulnerable women. Organizations like AOSI and OSI need to able to continue their important work in this arena without the potentially harmful limitations of the pledge requirement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 24, 2005
Baltimore, Maryland

Chris Beyrer

Exhibit A

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